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5/6/24

To: Dr. Bernet & the PASG

Re: Membership Application to the PASG

Hello Dr. Bernet,

You indicated in your email response to my application for membership to the PASG that you have questions you would like me to answer, and you have additional corrective actions you would like me to take regarding my prior criticisms of your professional positions.

I am happy to answer all questions you or the PASG Board of Directors may have, and I have provided my answers to your specific three questions in Appendix 1: Responses to PASG Membership Questions. Given our past disagreements about your seeming misdiagnosis and mistreatment of the child abuse pathology in the family courts, I believe an explanation to the PASG Board of Directors, and its membership is warranted regarding my motivations for seeking membership in the PASG. The answer is simple. The PASG purports to be a professional organization.

As a professional organization, I am seeking to activate the PASG into its professional obligations (duty to protect) for active advocacy (affirmative protective actions) for the protection of children from the child abuse currently occurring in the family courts that is undiagnosed and untreated. The pathology in the family courts is child abuse, Dr. Bernet – a DSM-5 diagnosis of V995.51 Child Psychological Abuse. All mental health professionals have duty to protect obligations – including all the mental health professionals of the PASG – including you. I am applying for membership to the PASG to assist the purported professional organization into its duty to protect obligations and active advocacy with the *Association of Family and Conciliation Courts* (AFCC) and the *American Psychological Association* (APA).

Child Abuse Pathology

My criticism of you and your friends is not personal, Dr. Bernet, it is professional. I believe you are failing in your professional obligations as a doctor – MD – in failing to accurately diagnose and properly respond to the child abuse pathology in the family courts. While I understand you are fixated on a "new pathology" proposal from a psychiatrist in the 1980s that has been rejected by the *American Psychiatric Association* as a being a real diagnostic entity, but that does NOT relieve you of your professional obligations as a doctor – MD – to accurately diagnose pathology and to inform your patients and the public of child abuse when child abuse is the diagnosis.

All mental health professionals have duty to protect obligations, including you, including all the professionals of the PASG. The only cause of severe attachment pathology (a child rejecting a parent), is child abuse range parenting by one parent or the other. The attachment system is a motivational system, not a regulatory system. All motivational

systems (eating, pleasure, pain, sex, attachment) have direction, as opposed to regulatory systems that can go either up or down. The attachment system always motivates in the direction of bonding toward the parent because the other direction it is death by starvation and predation (Bowlby).

I am noting Dr. Bernet, that if I must explain to you the functioning of the attachment system, then that would indicate that you are not competent in the assessment, diagnosis, and treatment of attachment pathology by demonstrated ignorance of the attachment system that requires my education of you (Google ignorance: lack of knowledge or information). Given that a child rejecting a parent is an attachment pathology, a problem in the love and bonding system of the brain, it is wondered why you have not engaged greater effort toward learning about and understanding the attachment system and attachment pathology in childhood (Google indolence: inclination to laziness: sloth). A child's life hangs in the balance of the court's decision, family courts are no place for professional ignorance and indolence. The pathology in the family courts is child abuse and professional duty to protect obligations are active.

Based on your vita, Dr. Bernet, it does not appear you have much background with the diagnosis and treatment of either child abuse or attachment pathology. This is a professional concern regarding your scope of competence when the pathology of concern is an attachment pathology and child abuse. Based on your public statements and writings, and your absence of *affirmative protective action* which is required when a mental health professional encounters a dangerous pathology (suicide, homicide, abuse), Dr. Bernet, it does not appear you understand that the pathology in the family courts is a DSM-5 diagnosis of Child Psychological Abuse (V995.51).

Whenever a mental health professional encounters any of three dangerous pathologies, suicide, homicide, and abuse (child, spousal, and elder abuse), duty to protect obligations are active and the mental health professional must EITHER personally conduct a proper risk assessment for the danger involved, OR take active (affirmative) steps to ensure that a proper risk assessment is conducted, and must chart their affirmative protective actions in the patient's medical record. If the protective actions are not charted in the patient's medical record, then they didn't happen.

This is the required professional response when possible child abuse is a consideration. All mental health professionals have duty to protect obligations and the pathology in the family courts involves two dangerous diagnoses, DSM-5 V995.51 Child Psychological Abuse and V995.82 Spouse or Partner Abuse, Psychological. The full DSM-5 diagnosis for the attachment pathology in the family courts (a child rejecting a normal-range parent) is:

- Delusional Disorder – persecutory type (shared)
  DSM-5 297.1 – ICD-10CM F22
- Factious Disorder Imposed on Another
  DSM-5 300.19 - ICD-10CM F68.10
- Child Psychological Abuse
  DSM-5 V995.51 - ICD-10CM T74.32

- Spouse or Partner Abuse, Psychological
  DSM-5 V995.82 - ICD-10CM Z69.11

I note again, Dr. Bernet, that if I need to educate you regarding child abuse pathology, risk assessments, safety plans, and professional duty to protect obligations, then you are not competent with child abuse pathology by demonstrated ignorance (lack of knowledge or information) that then requires that I educate you regarding your required professional obligations.

> **Google Duty to Protect:** In medical law and medical ethics, the duty to protect is the responsibility of a mental health professional to protect patients and others from foreseeable harm.

The AFCC & Forensic Custody Evaluations

My next step (*affirmative protective action*) in response to the child abuse pathology in the family courts is to join the *Association of Family and Conciliation Courts* (AFCC) and become an active participant in that professional organization. I will be bringing the Standards of the *American Psychological Association* ethics code with me, and I will be advocating that all – all – forensic psychologists are required to be competent (Standard 2.01 Boundaries of Competence) in all the necessary domains for the pathology in the family courts.

By affirming the DSM-5 diagnosis as a shared (induced) persecutory delusion and false (factitious) attachment pathology imposed on the child for secondary gain to the allied narcissistic-borderline-dark personality parent, multiple professional domains of knowledge become – required – for professional competence:

> **2.01 Boundaries of Competence**
> (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

Competence Domain 1: Delusional Thought Disorders

Writing in the journal, *Family Court Review* (the flagship journal of the AFCC), Walters and Friedlander (2016)[1] describe the shared persecutory delusion that emerges surrounding divorce and (induced) attachment pathology:

> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated **delusion** about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated **delusion** is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)

[1] Walters, M. G., & Friedlander, S. (2016). When a child rejects a parent: Working with the intractable resist/refuse dynamic. *Family Court Review, 54*(3), 424–445

From Walters & Friedlander: "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed **delusion** often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated **delusion** and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426).

Since the pathology in the family is potentially a persecutory delusion, ALL forensic psychologists must be competent in the diagnostic assessment of delusional thought disorders (Standard 2.01 Boundaries of Competence). The assessment for a delusional thought disorder is a Mental Status Exam of thought and perception as described by Martin (1990).[2]

From Martin: "Thought and Perception. The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?" (Martin, 1990).

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders." (Martin, 1990)

I have that "considerable experience" in the diagnostic assessment of delusional thought disorders from 12 years of annual training in the diagnostic assessment of delusional thought disorders using the *Brief Psychiatric Rating Scale* to r=.90 diagnostic reliability to the Co-Directors of the Brentwood-UCLA VA (and co-authors of the Expanded BPRS), Dr. Ventura and Dr. Lukoff.

9/85 - 9/98 Research Associate

UCLA Neuropsychiatric Institute
Principle Investigator: Keith Nuechterlein, Ph.D.

Area: Longitudinal study of initial-onset schizophrenia. Received annual training to research and clinical reliability in the rating of psychotic symptoms using the *Brief Psychiatric Rating Scale* (BPRS). Managed all aspects of data collection and data processing.

Competence Domain 2: Attachment

A child rejecting a parent is an attachment pathology. All forensic psychologists must therefore be competent in the diagnostic assessment and treatment of attachment

[2] Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, editors. Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition. Boston: Butterworths; 1990. Chapter 207. Available from: https://www.ncbi.nlm.nih.gov/books/NBK320/

pathology, based on their education, training, and (supervised) professional experience. The diagnostic issue in the family courts is whether the severe attachment pathology displayed by the child toward the targeted parent is authentic to that relationship (i.e., represents the child's response to abusive range parenting by the targeted parent that then reverses the direction of a primary motivational system) – OR – whether it is a false (factitious) attachment pathology (DSM-5 300.19 FDIA) being imposed on the child by the pathogenic parenting of the allied parent for secondary gain to that parent of manipulating the court's decisions regarding child custody. Professional competence is therefore required in BOTH the diagnostic assessment of authentic attachment pathology (authentic child abuse), AND with false (factitious) attachment pathology (FDIA).

Competence Domain 3: Factitious Disorder Imposed on Another

The pathology in the family courts is a false (factious; artificially created) attachment pathology imposed on the child by the pathogenic (pathology creating) parenting of the allied parent for secondary gain of manipulating the court's decisions regarding child custody, and to meet the pathological allied parent's own emotional and psychological needs – a DSM-5 diagnosis of Factious Disorder Imposed on Another (FDIA; 300.19).

Once again, Dr. Bernet, if I need to educate you about the DSM-5 diagnosis for the pathology in the family courts, that would seemingly indicate that you are not competent with the pathology in the family courts by demonstration of ignorance (lack of knowledge or information) that requires my education. If, on the other hand, you ARE aware that the pathology in the family courts is a shared (induced) persecutory delusion (DSM-5 297.1; shared), a false (factitious) attachment pathology imposed on the child by a pathological parent (DSM-5 300.19), and Child Psychological Abuse (DSM-5 V995.51) then your duty to protect obligations are (and have been) active. and *affirmative protective action* is required. In addition, the duty to protect obligations of all mental health professionals in the family courts are active.

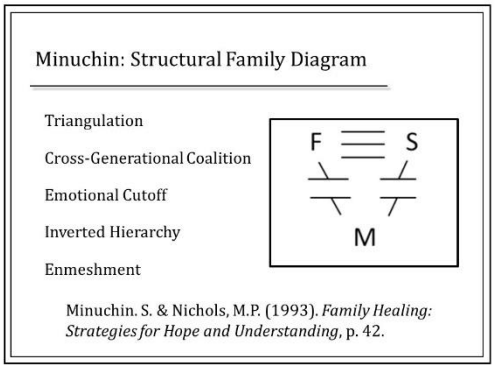
The differential diagnosis for the attachment pathology in the family courts is between 1) an authentic attachment pathology (caused by child abuse from the targeted parent), or 2) a false (factitious) attachment pathology (imposed on the child by the pathogenic[3] parenting of the allied parent). All forensic psychologists need to be competent in BOTH authentic attachment pathology AND factious disorders in order to make the necessary differential diagnosis.

Competence 4: Family Systems Pathology

When the the established professional knowledge of family systems therapy (Bowen, Minuchin, Haley, Madanes, Satir) is applied to understanding the pathology in the family courts, the family systems pathology of concern is the child's *triangulation* into the

[3] Pathogenic means creating pathology (patho=pathology; genic=creation). Pathogenic parenting refers to aberrant and distorted parenting practices that create pathology in the child – like parenting that creates a persecutory thought disorder and false (factious) attachment pathology.

spousal conflict through the formation of a *cross-generational coalition* with the allied parent against the targeted parent, that is producing an *emotional cutoff* in the child's attachment bond to the targeted parent. This family system pathology is depicted in a Structural family diagram from Minuchin and Nichols (1993).



All forensic psychologists who are assessing, diagnosing, and treating family conflict need to be competent in family systems constructs and pathology. Failure to possess the necessary education, training, and experience in family systems pathology when assessing, diagnosing, and treating family conflict would represent practice beyond the boundaries of professional competence in violation of Standard 2.01 of the APA ethics code.

Ethical Violations by Other Psychologists

As a clinical psychologist, I have – mandatory - ethical obligations required by Standards 1.04 and 1.05 when I believe there may have been an ethical violation by another psychologist (mental health professional).

> **1.04 Informal Resolution of Ethical Violations**
> When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.
>
> **1.05 Reporting Ethical Violations**
> If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities.

A child rejecting a parent is NOT a "resist-refuse dynamic", and pathogenic parenting that creates a shared (induced) persecutory delusion and false (factious) attachment pathology in the child is not "alienation". It is a DSM-5 diagnosis of V995.51 Child Psychological Abuse. By using the euphemisms of made-up pathology labels, Walters & Friedlander (2016) conceal that the pathology is Child Psychological Abuse behind their euphemisms that do NOT identify the child abuse - when it is clearly child abuse to create severe delusional and factitious pathology in the child

I believe that there are ethical violations by other psychologists, the forensic psychologists, of Standard 2.01 Boundaries of Competence. I have required – mandatory – obligations pursuant to Standard 1.04 and 1.05 of the APA ethics code.

Ethical practice is not optional, it is required – for them (Standards 2.01, 2.04, 9.01) and for me (Standards 1.04 & 1.05).

The challenge for parents, the reason they are unable to protect their children from psychological child abuse by the other parent, is that the targeted parents cannot get an accurate Child Psychological Abuse (DSM-5 V995.51) diagnosis for the pathology in their families - because the forensic psychologists (at the AFCC) are not competent in the necessary domains of knowledge – delusional thought disorders – attachment pathology – Factitious Disorder Imposed on Another – and family systems pathology.

The reason they are not competent in the necessary domains of knowledge needed for competence is that they are unethical psychologists who are in violation of Standard 2.01 of the APA ethics code. They are ignorant (lack knowledge or information) because they are unethical (Standard 2.01) and indolent in their professional obligations.

Then, because the forensic psychologists do not know what the pathology is (a violation to Standard 2.01), they then do not apply or rely on the established scientific and professional knowledge of the discipline (that they do not know) as the bases for their professional judgments, in violation to Standard 2.04 Bases for Scientific and Professional Judgments of the APA ethics code.

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The "established scientific and professional knowledge of the discipline" required for application with court-involved custody conflict is:

- Attachment pathology - Bowlby & others
- Family systems therapy - Bowen & others
- Child abuse and complex trauma – van der Kolk & others
- Personality disorder pathology - Beck & others
- Child Development – Tronick & others
- Psychological control – Barber & others
- DSM-5 diagnostic system - American Psychiatric Association

That then, becomes two ethical violations by the forensic psychologists at the AFCC, Standards 2.01 Boundaries of Competence (they do not know the necessary established knowledge) and 2.04 Bases for Scientific and Professional Judgments (they do not apply the established knowledge).

Because the forensic psychologists do not know the established scientific and professional knowledge of the discipline necessary for competence with the pathology (2.01), and because they do not apply the established knowledge (that they don't know) as

the bases for their professional judgments (2.04), their opinions as contained in their recommendations, reports, and diagnostic or evaluative statements, including their forensic testimony, are NOT based on information and techniques sufficient to substantiate their findings, in violation of Standard 9.01 Bases for Assessment of the APA ethics code.

> **9.01 Bases for Assessments**
> (a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

I believe there are multiple ethical violations (Standards 2.01, 2.04. 9.01) by other psychologists, a group of psychologists, the forensic psychologists in the family courts, that have substantially harmed and are likely to continue to substantially harm children and their parents in the family courts. I have mandatory obligations active under Standards 1.04 and 1.05 of the APA ethics code. I will be joining the AFCC to discharge both my ethical obligations and duty to protect by taking further action appropriate to the situation.

Participation in Child Abuse & Spousal Abuse

One of the prominent professional dangers surrounding this specific pathology, a shared persecutory delusion, is that if the involved forensic psychologists misdiagnose a shared persecutory delusion and believe the delusion is true, then the forensic psychologists become PART of the shared delusion, they become PART of the pathology.

When that pathology is the psychological abuse of the child by a pathological parent, then the forensic psychologists becomes PART of the parent's psychological abuse of the child because the psychologists were practicing beyond the boundaries of their competence in violation of Standard 2.01 and, as a result of their unethical practice, they misdiagnosed the pathology in the family – they believed a shared delusion was true, and so became PART of the shared delusion. The forensic psychologists became PART of the child abuse (because of their ignorance, incompetence, and unethical practice).

When the pathology is ALSO the psychological spousal abuse of the targeted parent by the allied parent using the child as the weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological), then the forensic psychologists <u>also</u> become participants in the spousal psychological abuse of the targeted parent because of their misdiagnosis of the pathology in the family. The targeted parents may have legal options for damages caused by their (spousal) abuse received from the forensic psychologists who negligently misdiagnosed the pathology in the family.

Follow along:

- The forensic psychologists violated Standard 2.01 by not knowing the necessary established knowledge needed for competence with the pathology, i.e., unethical practice.
- Because of their unethical practice, the forensic psychologists misdiagnosed a shared persecutory delusion and became PART of the shared delusion.

- Because they believe a shared delusion (because of their unethical and incompetent malpractice – Standards 2.01, 2.04, 9.01), the forensic psychologists become **participants** in child abuse and spousal abuse by the allied parent (using the child as the weapon).

Do you comprehend that linear-logical line of reasoning, Dr. Bernet? If you do, then I have another linear-logical line of reasoning for you to consider:

- The pathology in the family courts is child abuse (DSM-5 V995.51 Child Psychological Abuse).

- Using euphemisms of made-up pathology labels like "parental alienation" – "resist-refuse dynamic" – and "Parent-Child Contact Problems" hides the FACT that it is child abuse by NOT calling it child abuse.

- The pathology (problem) is NOT "parental alienation" – the pathology (problem) is NOT "resist-refuse dynamic" – the pathology (problem) is NOT "Parent-Child Contact Problems" – the pathology, the problem, is child abuse (DSM-5 V995.51 Child Psychological Abuse).

- When professionals use euphemisms of made-up pathology labels for the child abuse in the family courts, they HIDE the child abuse that is occurring - and - they instead lead everyone into conflict and "controversy" as to whether their proposed made-up pathology labels ("parental alienation" – "resist-refuse dynamic" – "Parent-Child Contact Problems") even exist.

- By leading everyone into conflict and "controversy", these irresponsible mental health professionals degrade the quality of mental health services available to children, their parents, and the courts by NOT first applying the established knowledge of the discipline as the bases for their professional judgments – which would return a DSM-5 diagnosis of:

  Delusional Disorder – persecutory type (shared)
  DSM-5 297.1 – ICD-10CM F22

  Factious Disorder Imposed on Another
  DSM-5 300.19 - ICD-10CM F68.10

  Child Psychological Abuse
  DSM-5 V995.51 - ICD-10CM T74.32

  Spouse or Partner Abuse, Psychological
  DSM-5 V995.82 - ICD-10CM Z69.11

- By continuing to use euphemisms of made-up pathology labels for the child abuse in the family courts, these irresponsible mental health professionals **participate** in covering up the child abuse, and they further participate in the child abuse by degrading the quality of mental health services provided to children, their parents, and the courts.

Did that make sense to you too, Dr. Bernet? That is the reason I have been steadfastly requesting that ALL responsible mental health professionals STOP using euphemisms for the child abuse like "parental alienation", "resist-refuse dynamic", and "Parent-Child Contact Problems", and rely ONLY on the established scientific and professional knowledge of the discipline, that will then accurately diagnose the pathology as V995.51 Child Psychological Abuse (297.1 Delusional Disorder, shared; 300.19 FDIA), and as spousal psychological abuse of the targeted parent by the allied parent using the child as the weapon (DSM-5 V995.82).

NY Blue Ribbon Commission

The forensic psychologists have already received a scathing critique from the *New York Blue Ribbon Common on Forensic Custody Evaluations* who concluded that forensic custody evaluations lack scientific and legal value, result in defective reports, are harmful to children, and are potentially dangerous. The *NY Blue Ribbon Commission* found the practice of forensic custody evaluations to be beyond reform, and they voted 11-to-9 in favor of completely eliminating forensic custody evaluations from the family courts.

> **From NY Blue Ribbon Commission:** "Ultimately, the Commission members agree that some New York judges order forensic evaluations too frequently and often place undue reliance upon them. Judges order forensic evaluations to provide relevant information regarding the "best interest of the child(ren)," and some go far beyond an assessment of whether either party has a mental health condition that has affected their parental behavior. In their analysis, evaluators may rely on principles and methodologies of dubious validity. In some custody cases, because of lack of evidence or the inability of parties to pay for expensive challenges of an evaluation, defective reports can thus escape meaningful scrutiny and are often accepted by the court, with potentially disastrous consequences for the parents and children… As it currently exists, the process is fraught with bias, inequity, and a statewide lack of standards, and allows for discrimination and violations of due process."

> **From NY Blue Ribbon Commission:** "By an 11-9 margin, a majority of Commission members favor elimination of forensic custody evaluations entirely, arguing that these reports are biased and harmful to children and lack scientific or legal value. At worst, evaluations can be dangerous, particularly in situations of domestic violence or child abuse – there have been several cases of children in New York who were murdered by a parent who received custody following an evaluation. These members reached the conclusion that the practice is beyond reform and that no amount of training for courts, forensic evaluators and/or other court personnel will successfully fix the bias, inequity and conflict of interest issues that exist within the system."

Forensic custody evaluations are a failed experiment in service delivery to a vulnerable population. It was an experiment in a new type of assessment procedure not grounded in the foundations of healthcare and *diagnosis* (clinical psychology). They did something different. It failed.

> **From Simon & Stahl (2020):** "Despite what we see as a clear and convincing argument for using a forensically informed model when conducting child custody

evaluations, there are still those who argue that a clinically informed approach to child custody evaluations is appropriate and preferable. We disagree with the clinically informed approach." (p. 10)[4]

The forensic psychologists openly admit that they do NOT rely on the established scientific and professional knowledge of the discipline that they obtained through their doctoral education in psychology:

> **Simon & Stahl 2020:** "Because a good deal of clinical "data" is impressionistic, subjective, and not subject to transparent replication, FMHPs [forensic mental health professionals] must reorient their thinking away from much of what was learned in Graduate School and toward the demands of forensic practice." (p. 19)

The forensic psychologists gave themselves permission to simply make things up regarding their new "evaluation" approach. It was an experiment on the children and parents in the family courts with a new type of assessment procedure that did NOT rely on a "clinically informed approach" (diagnosis and treatment), and did NOT rely on "what was learned in Graduate School" – and – despite 40 years of their experiment in service delivery (to a vulnerable population), they still, in 2020, remain in their "formative years" with their new experimental approach to the assessment of pathology and its treatment (identifying the problem and fixing it).

> **From Simon & Stahl (2020):** "This illustrates the reality that as an organized field and as an organized, systematic approach to behavioral science, forensic psychology remains in its formative years." (p. 17)

Clinical psychology (diagnosis and treatment) needs to return to court-involved custody conflicts. Forensic custody evaluations can take 6-to-9 months (this is excessively long when child abuse is the differential diagnosis), and they can cost between $20,000 to $40,000. A clinical diagnostic risk assessment to the diagnoses of concern would be estimated to cost around $5,000 ($10,000 with telehealth second opinion) and could be returned in about 4-to-6 weeks.

My current role in the family courts is twofold, 1) reviewing mental health reports (often forensic custody evaluations) to apply the established knowledge of clinical psychology to the information I am asked to review, and 2) providing second opinion through telehealth consultation to active assessments being conducted by on-site local area mental health professionals. Forensic custody reports are leaving. They are a failed experiment in service delivery to a vulnerable population. I will be scaffolding through telehealth consultation the return of clinical psychology (diagnosis & treatment) to the family courts.

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[4] Simon & Stahl (2020): *Forensic Psychology Consultation in Child Custody Litigation: A Handbook for Work Product Review, Case Preparation, and Expert Testimony* (2nd edition). American Bar Association.

The time for the "study" of child abuse has long-ago passed, Dr. Bernet. The pathology in the family courts is child abuse (and spousal abuse using the child as the weapon). Duty to protect obligations are active for all court-involved mental health professionals to EITHER 1) personally conduct a proper risk assessment for the danger involved, or 2) ensure that a proper risk assessment is conducted.

While each individual mental health professional can return an accurate diagnosis in their individual practices, the child abuse (and professional incompetence) is widespread and unchecked throughout the family court system. Our professional obligations are therefore to work toward obtaining the proper risk assessment from the larger community systems than just our personal practices. We need to activate appropriate elements of the mental health system into their professional duty to protect obligations – which I propose involves helping the currently dysfunctional forensic psychology system in the family courts transition into a proper child protection response.

The Parental Alienation Study Group

I will be joining the AFCC to work for the necessary changes to professional psychology that are needed to protect children and their parents in the family courts from psychological child abuse and spousal abuse by a pathological narcissistic-borderline-dark personality parent.

Just as I will be seeking to activate the professional organization of the AFCC into its protective role, I am similarly seeking to activate the professional organization of the PASG into its protective obligations. All mental health professionals have duty to protect obligations, including you, including all the professionals of the PASG, including all the professionals at the AFCC. The pathology is child abuse. I would propose that the PASG no longer needs to "study" child abuse (never did; Cicchetti), and that instead *affirmative protective action* is required.

1. From Study to Action

I propose that the PASG bring its "study" of child abuse to an end and that the PASG make a formal "Determination" (diagnosis) that the pathology in the family courts is Child Psychological Abuse (DSM-5 V995.51) and spousal psychological abuse of the targeted parent using the child as the weapon (DSM-5 V995.82 Spouse or Partner Abuse, Psychological), and that *affirmative protective action* from the PASG is required by professional standards of practice surrounding child abuse.

I propose that the PASG then expand its "study" of child abuse in the family courts to enter active advocacy with involved local and national stakeholders (e.g., AFCC – APA – *American Bar Association*) for an enhanced and more effective child protection response in the family courts.

2. End the Professional Staff Spitting

We need to end the professional fighting surrounding these children. The way to accomplish that is for all – all – mental health professionals to rely ONLY on the "established scientific and professional knowledge of the discipline" as the bases for

professional judgments. All. That means the DSM-5 diagnostic system of the *American Psychiatric Association*.

I propose that the PASG issue a 2-page formal Diagnostic Statement for the Family Courts co-authored by Dr. Bernet & Dr. Childress that clearly provides the following DSM-5 diagnosis for the attachment pathology that is often encountered in the family courts surrounding high-conflict custody litigation:

- Delusional Disorder – persecutory type (shared)
  DSM-5 297.1 – ICD-10CM F22
- Factious Disorder Imposed on Another
  DSM-5 300.19 - ICD-10CM F68.10
- Child Psychological Abuse
  DSM-5 V995.51 - ICD-10CM T74.32
- Spouse or Partner Abuse, Psychological
  DSM-5 V995.82 - ICD-10CM Z69.11

3. Moderated Online Debates

I propose that the PASG sponsor a series of online moderated Debates and Panels regarding areas of concern in the family courts that will provide an online professional-level resource of information examining the issues in the family courts fully and from multiple perspectives, to improve decision-making surrounding children in the family courts.

I would propose a focus on forensic custody evaluations, with the argument offered by PASG that forensic custody evaluations need to end and that clinical diagnostic assessments need to return to court-involved custody conflict.

I propose that the PASG reach out to leaders of forensic psychology (I would propose the starting names of Dr. Stahl, Dr. Simon, and Dr. Deutsch) offering the opportunity to defend their position in favor of forensic custody evaluations against the PASG position represented by Dr. Childress of a return to a clinical diagnostic model of assessment (a "clinically informed approach").

Debate: The Role of Forensic & Clinical Psychology in the Family Courts

Clinical Psychology: Dr. Childress

Forensic Psychology: Dr. Simon (Dr. Stahl, Dr. Deutsch, Dr. Sullivan, Dr. Drozd; AFCC Representative)

<u>PASG Research Study</u>

If the PASG wants to continue its "study" of the child abuse in the family courts, I suggest a research study on *Forensic Psychology Responsiveness to Critical Self-Examination*.

- Start by asking the AFCC to supply a representative for your Debate topic - look to their current leadership for a possible offer of names.
- If they decline, then next sequentially invite 10 top forensic psychologists until either one agrees to Debate on the topic or everyone declines. Do that for three Debate topics. Then publish the results – or – start hosting online moderated Debates on the various issues in the family courts if they agree.

Controversy draws attention. The "controversy" currently in the family courts surrounding made-up pathology labels needs to be more productively realigned to controversy regarding the undiagnosed child abuse. The professional allies of the targeted parent and authentic child need to switch from a defense position of 'pleading to be accepted' to offense – and the professional arguments we make need to place the allies of the pathology on the defensive – "tell us why it's not a persecutory delusion" – "tell us why it's not a false (factitious) attachment pathology" – "tell us why it's not Child Psychological Abuse (DSM-5 V995.51)".

Because if it IS a shared persecutory delusion – if it IS a false (factitious) attachment pathology imposed on the child – and if it IS child psychological abuse – (and it is) - and they DON'T conduct a proper risk assessment for a possible induced (shared) persecutory delusion and FDIA, then they – the forensic psychologists - could face sanctions to their license for a negligent failure in their duty to protect obligations.

I will provide the "controversy" with my (supported) allegations against the forensic psychologists of unethical malpractice leading to misdiagnosis – leading to their participation in the psychological abuse of children and their parents. Greater outside attention to the struggles of parents in the family courts would be beneficial for the struggling families. Greater attention would also be good for the PASG as the "leading" professional organization offering international Education & Advocacy to end the "child abuse" in the family courts. I will provide the "controversy" and challenges to the existing status quo. I am suggesting that the PASG become the focusing lens for the challenging information that the pathology is… child abuse.

Additional Possible Debate Topics:

Debate: Is the Pathology in the Family Courts Child Psychological Abuse?

Yes: Dr. Childress

No: Sequentially invite 10 top forensic psychologists and ask the AFCC for a representative. Either they all say no or one says yes.

Debate: Are Forensic Custody Evaluations a Failed Experiment in Service Delivery?

Yes: Dr. Childress

No: Sequentially invite 10 top forensic psychologists and ask the AFCC for a representative. Either they all say no or one says yes.

If they all say no, that is a revealing response (ask them why for a 'follow-up' data point) and is worth a journal article if the data collection is clean. If one says yes, then PASG

is hosting an online moderated Debate that draws attention to the issue, attention to the families, and attention to the PASG as the source of professional advocacy for children and parents in the family court systems.

Debating "New Pathology" Proposals

I understand that you remain fixated on a made-up pathology label from a psychiatrist in the 1980s that has failed to solve anything in its 40 years of existence. If you would like, we can use the online moderated Debates of the PASG to allow you to make your case for the pathology NOT being child abuse, NOT being a shared delusion, NOT being FDIA, and instead being an entirely new form of pathology that you are discovering called "parental alienation". Perhaps the PASG could form a "Panel Discussion" format by including forensic psychologists, perhaps in collaboration with the AFCC. We have the Internet. We should be using it.

> **Panel Discussion:** Are Parental Alienation, Resist-Refuse Dynamic, and Parent-Child Conflict Problems Real Pathology or Euphemisms that Hide Child Abuse?
>
> Yes - Parental Alienation (PA) is a Real Pathology: Dr. Bernet or a friend
>
> Yes - Resist-Refuse Dynamic (RRD) is a Real Pathology: a forensic psychologist or AFCC representative
>
> Yes - Parent-Child Conflict Problems (PCCP) is a Real Pathology: a forensic psychologist or AFCC representative
>
> No - They are Euphemisms that Hide Child Abuse: Dr. Childress

Treatment Teams

I have worked within treatment teams my entire professional career, Dr. Bernet, starting at the Suicide Prevention Center as an undergraduate psychology major doing telephone crisis counseling within a supportive consultation framework, to my work as a pediatric psychologist on medical treatment teams at Children's Hospitals, to my time leading treatment teams surrounding children in foster care that included CPS social worker involvement. I note on your vita that you have been a professor. Have you worked as part of a treatment team, Dr. Bernet?

If you have, then you know there is a professional *hierarchy* of authority within a clinical treatment team, with one doctor, the most central doctor, typically taking charge to lead the treatment team, and the other professionals adopt their supporting roles based on their disciplines; nurses handle medical treatments, social workers line-up financial and social support services, psychologists do testing and psychotherapy, psychiatrists prescribe medication. For example, as a pediatric psychologist on a treatment team for a child's cancer diagnosis at Children's Hospital, my role is one of support, with the primary medical physician for the child's cancer assuming the treatment team leadership role with the various associated supporting professionals.

For attachment pathology, Dr. Bernet, the clinical psychologist on the team would lead the treatment team, not the MD psychiatrist. Attachment is the domain of psychologists, not MD psychiatrists (who are more typically in the role of medication support on a treatment team). Leadership of the treatment team for attachment pathology and child abuse would typically fall to the involved clinical psychologist, with the psychiatrist in a supporting medication role. This would especially be the case when the involved clinical psychologist has Early Childhood Mental Health specialization (attachment specialization) and high-level background in treating child abuse.

Dr. Childress: Early Childhood & Attachment Training & Experience

Early Childhood Training:

- Pre-doctoral and post-doctoral training with Marie Poulsen, Ph.D. in the Early Childhood Mental Health rotation at Children's Hospital Los Angeles
- Certificate Program: Parent-Infant Mental Health: Fielding Graduate University, 1/14/08; 1/15/08.

Training in Early Childhood Diagnostic Systems

- Early Childhood Diagnostic System: *DC:0-3R Diagnostic Criteria*: Orange County Early Childhood Mental Health Collaborative.
- Early Childhood Diagnostic System: *DMIC: Diagnostic Manual for Infancy and Early Childhood.* Interdisciplinary Council on Developmental and Learning Disorders: assessment, diagnosis, and intervention for developmental and emotional disorders, autistic spectrum disorders, multisystem developmental disorders, regulatory disorders involving attention, learning and behavioral problems, cognitive, language, motor, and sensory disturbances.

Training in Early Childhood Attachment Treatments

- Early Childhood Treatment Intervention: *Watch, Wait, and Wonder*: Nancy Cohen, Ph.D. Hincks-Dellcrest Centre & the University of Toronto.
- Early Childhood Treatment Intervention: *Circle of Security*: Glen Cooper, MFT, Center for Clinical Intervention, Marycliff Institute, Spokane, Washington.

Clinical Experience in Early Childhood, Attachment, & Child Abuse

- **10/06 - 6/08: Clinical Director**
  START Pediatric Neurodevelopmental Assessment and Treatment Center
  California State University, San Bernardino
  Institute of Child Development and Family Relations

  Clinical Director for an early childhood assessment and treatment center providing comprehensive developmental assessment and psychotherapy services to children ages 0-5 years old in foster care. The primary referral source for the clinic was Child Protective Services. Directed the clinical operations, clinical staff, and the provision of comprehensive psychological assessment and

treatment services across clinic-based, home-based, and school-based services. The clinic was a three-university collaboration, with speech and language faculty and services through the University of Redlands, occupational therapy faculty and services through Loma Linda University, and psychology faculty and clinical staff through Calif. State University, San Bernardino.

I have reviewed your vita, Dr. Bernet. I believe you graduated medical school in 1967 as a medical doctor (i.e., you have no education or training in psychology or psychotherapy). You were a professor at the Vanderbilt School of Medicine for 20 years, from 1992 until your retirement in 2012, indicating your responsibilities to be: "I teach topics related to psychiatry to psychiatry residents, child psychiatry fellows, medical students, and nursing students", and you indicate that "My medical practice related primarily to forensic evaluations involving children, adults, and families."

Q: Would these be the same type of forensic custody evaluations that are so harshly critiqued by the *NY Blue Ribbon Commission on Forensic Custody Evaluations* as lacking scientific and legal value and being harmful to children?

I offer to you, Dr. Bernet, that I have substantially more relevant professional experience with attachment pathology (Early Childhood Mental Health), than you do – and the pathology in the family courts is an attachment pathology – a child rejecting a parent – a problem in the love-and-bonding system of the brain.

I further offer to you, Dr. Bernet, that you are likely not competent in attachment pathology – especially not sufficiently competent to lead the treatment team for the children and parents in the family courts. While you are an MD medical doctor and should be practicing at a professional level – you are not. I am leading the treatment team for the children and parents in the family courts – not you. If you – or anyone – wants to challenge my professional leadership of the treatment team for the children and parents in the family courts – bring your vitae and your arguments and we can discuss the leadership for the treatment team - Debate. Because otherwise, I'm leading the treatment team for these children and families because someone has to do it and I have experience leading treatment teams for child abuse.

Debate: Who Should Lead the Treatment Team for Children & Parents in the Family Courts?

Dr. Childress: Dr. Childress

Dr. Bernet: Dr. Bernet

A 90-minute online moderated Debate

Criticisms of You and Your Friends

You are correct that I have been direct and blunt in my criticisms of you and your friends, Dr. Bernet. I also understand that you are asking that I remove all the negative

things I have said about your standards of professional practice, your irresponsible professional judgment, and your flawed decision-making. If it would help end the child abuse one day earlier, Dr. Bernet, I would be happy to remove all my negative statements about the professional practices and the decision-making of you and your friends.

- Please identify which of my statements critical of you and your friends you want me to remove, and I shall remove them.

However, just so that you know, I will continue to criticize your professional standards of practice and professional judgment in my professional reports to the court where I must tell the truth. For your awareness, the following is my standard response when your 2020 article with Dr. Lorandos on "parental alienation" is sometimes cited by a mental health professional:

> **From the Reports of Dr. Childress:** "The Gardnerian PAS "experts" represent a fringe group of professionals who reject the diagnostic guidance of the *American Psychiatric Association* (because they believe they know more about diagnosis than the *American Psychiatric Association* does), and who reject the ethical guidance of the *American Psychological Association* (because they believe that ethical standards of practice do not apply to them). The use of the construct of "parental alienation" in a professional capacity is substantially beneath professional standards of practice in clinical psychology and is in violation of Standard 2.04 Bases for Scientific and Professional Judgments of the APA ethics code. The use of the construct of "parental alienation" in a professional capacity degrades the quality of mental health services in the family courts and colludes with the psychological abuse of children in covering-up the child abuse by using euphemisms of made-up pathology labels.

You are a group of fringe mental health professionals, Dr. Bernet. That is a fact of reality. In 2013, the *American Psychiatric Association* said there was no defined pathology called "parental alienation." All normal-range mental health professionals rely on the DSM-5 for diagnoses, Dr. Bernet. Only you and your friends feel the need to expand your diagnostic scope into rejected forms of pathology. When you do so, you leave the world of established professionals and you become a fringe professional – who rejects the diagnostic guidance of the *American Psychiatric Association* (it is a shared persecutory delusion, FDIA, and Child Psychological Abuse V995.51) – and who rejects the ethical guidance of the *American Psychological Association* that REQUIRES the application of the established scientific and professional knowledge of the discipline – first – not after – not instead of. First.

I would suggest to you, Dr. Bernet, that greater benefit could be achieved if you were to self-reflect on the content of my criticisms of your professional activity. If, however, you wish me to remove all my negative opinions regarding your standards of professional practice and flawed decision-making as a condition of allowing the PASG to activate into its duty to protect obligations and an active advocacy role, then please indicate which statements are distressing to you and your friends and I will remove them from the Internet (with the caveat that I must still tell the truth in my reports to the court).

Truth

In relying on rejected pathology proposals rather than the DSM-5, you become a fringe professional who is practicing outside the bounds of normal-range standards of practice. That is the truth. I am not responsible for the truth of your professional standards of practice – you are. Every other responsible doctor relies on the DSM-5 for diagnoses – except you, Dr. Bernet.

- The pathology in the family courts is a shared (induced) persecutory delusion (DSM-5 297.1, Delusional Disorder, shared).

- The pathology in the family courts is a false (factious) attachment pathology imposed on the child by a narcissistic-borderline parent for secondary gain to the pathological parent (DSM-5 300.19 FDIA).

- The pathology in the family courts is child abuse (V995.51 Child Psychological Abuse)

  That is the truth.

It is true that you do disregard the diagnostic guidance of the *American Psychiatric Association* in continuing to believe that you are discovering a new form of pathology, called "parental alienation". I am not responsible for your fixed and false (grandiose) belief that you know more about pathology than the *American Psychiatric Association* and that you are discovering a "new form" of pathology called "parental alienation" – it is you who believes you know more about pathology than the *American Psychiatric Association* does.

You disagree with the *American Psychiatric Association* regarding diagnosis, and you reject their diagnostic guidance. I agree with the *American Psychiatric Association's* judgment on "parental alienation", and I rely on the DSM-5 for my professional diagnosis. I am mainstream. You are not. You believe that the *American Psychiatric Association* is wrong and you are right. I believe the *American Psychiatric Association* is right and that you are wrong.

The truth is that you do reject the diagnostic guidance of the *American Psychiatric Association*, Dr. Bernet, because of your (grandiose) belief that you are discovering a "new form" of pathology with a new pathology-label you made up. If you do not like the truth, then change the truth and reestablish your ground within the established professional standards of doctors who are – required - to make accurate diagnoses using established knowledge and to provide accurate information to their patients and the public.

You also disregard the ethical guidance of the *American Psychological Association* for the required application of established scientific and professional knowledge as the bases for your professional judgements – first – before your "new pathology" proposals – not after you propose a "new pathology" – you are required to apply established knowledge first - before making a "new pathology" proposal. That is professionally responsible behavior from all responsible doctors.

Based on your vita and your writings, Dr. Bernet, I believe there may be violations to two ethical Standards, 2.01 Boundaries of Competence and 2.04 Bases for Scientific and Professional Judgments, by another doctor – and I am bringing my concerns for seemingly unethical practice to your attention pursuant to my – required – ethical obligations under Standard 1.04 of the APA ethics code, with the hope that the ethical concerns surrounding your competence with attachment pathology and child abuse are properly resolved in that fashion.

Questions for Dr. Bernet

You asked me some questions. I have several questions for you in return.

I assert that you are a poor diagnostician. I assert that during your forensic psychiatry practice from 1992 until the DSM-5's publication in 2013, you misdiagnosed a shared persecutory delusion, **DSM-IV** 273.5 Shared Psychotic Disorder, the entire tenure of the **DSM-IV** (11 years of misdiagnosis), and that you have continued to misdiagnose the Child Psychological Abuse (DSM-5 V995.51) and a shared persecutory delusion, and FDIA, and spousal psychological abuse, for the past 10 years since the publication of the DSM-5 because of your rigidly held, fixed and false (grandiose) belief that you are discovering a "new pathology" that you call "parental alienation".

Please reassure me that you do comprehend that the pathology in the family courts is a shared (induced) persecutory delusion, is a false (factious) attachment pathology, and is child abuse by clearly communicating your DSM-5 diagnosis for the pathology in the family courts. The reason that professionals use professional-level terms is for clarity in communication – please, for a moment, return to being a professionally responsible doctor and report on your diagnosis using professional-level terms:

Dr. Bernet Questions:

1) **Delusional Thought Disorder:** Is the pathology in the family courts a shared (induced) persecutory delusion (DSM-5 297.1)? ☐ yes ☐ no
2) **FDIA:** Is the pathology in the family courts a false (factious) attachment pathology imposed on the child for secondary gain to the pathological parent (DSM-5 300.19) ☐ yes ☐ no
3) **Child Abuse:** Is the pathology in the family courts Child Psychological Abuse (DSM-5 V995.51)? ☐ yes ☐ no
4) **Spousal Abuse:** is the pathology in the family courts spousal psychological abuse of the targeted parent by the allied parent using the child as the weapon? ☐ yes ☐ no
5) **Solution:** What is your proposed path to a solution for the family courts using the construct of "parental alienation" (PAS)?

Membership Application

The pathology in the family courts is child abuse. I understand that. I have duty to protect obligations (as do all involved mental health professionals) to take affirmative

protective action and to document that action in the patient's medical record. Pursuant to my required ethical obligations under Standards 1.04 and 1.05 of the APA ethics code, I am taking further action as appropriate in response to the abundant ethical violations by other psychologists within the family courts (Standards 2.01, 2.04, 9.01). I will be seeking to activate professional organizations in the family courts into their protective obligations to take affirmative action to protect the children (and their parents) in the family courts from abuse by a pathological (narcissistic-borderline-dark personality) parent.

I have provided my specific answers to your specific three questions regarding my membership application in Appendix 1, and I have provided this broader explanation regarding my motivations and obligations. I plan to be joining the AFCC next, and it is the AFCC that is the focus of my efforts. I am seeking to activate the involved professional organizations into a protective role of active advocacy that will lead to productive changes that protect all children from all forms of child abuse 100% of the time.

In closing, I offer a recent Declaration I made to the court regarding material I was asked to review in a court matter (Appendix 2: Competence Declaration). The attorney in the matter asked that I review a set of information and apply the established knowledge of clinical psychology to the material because the attorney believed that the application of the established knowledge from clinical psychology to the set of information would assist the court in its decision-making surrounding the child. Among the information I was asked to review was a report by an involved psychologist and their Curriculum Vita, and I was asked for an opinion. I provided my opinion to the attorney. Appendix 2, my Competence Declaration, is my opinion.

I will be encountering forensic psychologists. After 40 years of failure from the experimental approach of forensic custody evaluations, professional psychology in the family courts needs to re-establish professional standards of practice for competence that ALL mental health professionals can be held accountable for. I am relying on the ethics code of the *American Psychological Association* as those Standards because my focus is directed toward the forensic psychologists in the AFCC. I understand that you do not like when I hold you <u>accountable</u> for professional and ethical standards and obligations, and I suspect the forensic psychologists will like it even less – yet they are in violation of multiple ethical standards – and they are misdiagnosing the shared delusion because they are unethical and not competent with the pathology – and as a result, they are (ignorantly and negligently) participating in psychological abuse of the child.

I suspect some of the forensic psychologists will find my challenges to their unethical malpractice to be "rude", and they will likely be upset at being called "ignorant" (lack of knowledge or information) when I have to educate them about established knowledge in order to explain the pathology to the – doctors. It is not my job to educate them. It is their obligation to already know (Standard 2.01).

Craig Childress, Psy.D.
Clinical Psychologist, CA PSY 18857

Appendix 1: Responses to PASG Membership Questions from Dr. Bernet

Hello Dr. Bernet,

As you are aware, I have applied for membership with the Parental Alienation Study Group (PASG), and you responded with an email asking me several questions before approving my membership to the PASG. I am providing this response to your questions in support of my application to the PASG. I also noted in your email your intent to discuss my application for membership with the Board of Directors for PASG. I am available to answer any additional questions they may have.

I will address each of your questions in turn:

> Hello Craig,

To begin, Dr. Bernet, I request that you address me as Dr. Childress, it is an indication of professional respect, and I take note the professional disrespect in the informality you assume with me. Please provide me with professional respect.

> I see that you have applied for membership in PASG. Before we can proceed with your application, we need some additional information from you. Please prepare a brief statement in which you address …

I will address each request for additional information in turn.

> How will you support the goals of PASG, as expressed on our website, www.pasg.info?

Question 1: How will I support the goals of PASG as expressed on the PASG website?

- I will work tirelessly with forthright professional truthfulness and required adherence to professional ethical standards to protect the children and their parents in the family courts from the child abuse and spousal abuse they have endured through the past 40 years of forensic psychology in the family courts.
- I will apply all of my knowledge and skills as a clinical psychology gained from a lifetime of experience to the goal of ending the child abuse and spousal abuse pathology currently undiagnosed and untreated in the family courts.
- I will promote the application of the established scientific and professional knowledge of the discipline of professional psychology as the bases for professional judgments in the family courts, consistent with required ethical obligations under Standard 2.04 Bases for Scientific and Professional Judgments of the ethics code for the American Psychological Association.

- I will actively advocate for compliance to ethical standards for competence from all mental health professionals in the family courts in accord with each discipline's code of ethics, to bring competent diagnosis and effective treatment to the children and parents in the family courts.

I am applying for membership to the professional organization of the PASG to initiate collaboration toward a common purpose of ending the child abuse and spousal abuse in the family courts, pursuant to our shared duty to protect obligations.

> Over the years, you have posted on your website, Facebook page, and perhaps other platforms extremely negative and rude statements regarding PASG members (including Linda Gottleb, Demosthenes Lorandos, and me). Do you agree to remove those offensive statements from the internet, as well as others that might be identified?"

Question 2: Do I agree to remove all public statements that you identify which you believe are critical of you, Wiliam Bernet, MD, Linda Gottlieb, MSW, and Demosthenes Lorandos, PhD?

Yes.

If that will help end the child abuse and spousal abuse one day earlier, absolutely. Please identify the statements that I have made about you that you want me to remove from view that are critical of the decisions, ethical compliance, and professional standards of practice of you and your friends.

Will that include my Facebook Post on 4/19/22[5] regarding my prominent professional concerns about Ms. Gottlieb's Turning Points experimental treatment program for severe attachment pathology based on my review of reports she wrote for the court regarding her treatment? I would offer that all my statements about you, Ms. Gottlieb, and Dr. Lorandos are valid professional concerns for competence and unethical practice, and relative to Dr. Lorandos I have mandatory – required – ethical obligations set forth by Standards 1.04 and 1.05 of the APA ethics code. Do I need to remove the criticisms of you and your friends if they are true?

> **1.04 Informal Resolution of Ethical Violations**
> When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

I would challenge that your 2020 article on a five-part model of "parental alienation" is seemingly in violation of Standard 2.04 Bases for Scientific and Professional Judgments of

[5] Gottlieb Turning Points Warning:
https://www.facebook.com/profile/1586605354/search/?q=turning%20point

the APA ethics code that requires Dr. Lorandos to rely on established knowledge; i.e., the DSM-5 when discussing psychiatric pathology (delusions and FDIA), applied attachment knowledge when discussing attachment pathology, knowledge about child abuse and complex trauma when discussing child abuse and complex trauma pathology, personality disorders when discussing personality disorder pathology, and family systems constructs when discussing family conflicts – I saw none of this established knowledge was relied on by you and Dr. Lorandos as the bases for your professional judgments – in apparent violation to Standard 2.04 of the APA ethics code. Or don't you care about ethical standards? Perhaps you believe that ethical standards don't apply to you and your friends?

> **2.04 Bases for Scientific and Professional Judgments**
> Psychologists' work is based upon established scientific and professional knowledge of the discipline.

As a consultant in the family courts, I have had the opportunity to review a professional report from Dr. Lorandos. I was not asked for an opinion on his report in the matter, but if I had been asked, I would have raised Standard 2.01 and 2.04 concerns that would likely trigger my – mandatory – ethical obligations under Standards 1.04 and 1.05 of the APA ethics code. Please convey to Dr. Lorandos my professional concerns about his compliance with Standards 2.01 and 2.04 next time you talk with him, pursuant to my obligations under Standard 1.04 for an "informal resolution" of bringing my concerns to his attention.

> **2.01 Boundaries of Competence**
> (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

I question (and challenge) the competence of Dr. Lorandos and Ms. Gottlieb, a social worker, in multiple domains of knowledge necessary for professional competence with the family court pathology. Are you suggesting that the professional competence and ethical compliance of mental health professionals you like should not be questioned or challenged? My concerns are primarily in three domains of competence:

- **Delusional Thought Disorders:** the diagnostic assessment of delusional thought disorders (Mental Status Exam of thought and perception)
- **Attachment Pathology:** the diagnostic assessment and treatment of attachment pathology
- **Factitious Disorders:** the diagnostic assessment and treatment of factitious disorders

In your case as a medically trained psychiatrist, Dr. Bernet, I question (and challenge) your competence in the diagnosis and treatment of attachment pathology - a child rejecting a parent is an attachment pathology – and typically attachment expertise is obtained in an Early Childhood Mental Health professional specialization. Furthermore, your continued

reliance on "new pathology" proposals that have been rejected by the *American Psychiatric Association*, in lieu of relying instead on the application of the actual psychiatric diagnoses of delusional thought disorders and factitious disorder imposed on the child, is of additional concern. This raises the professional level question of whether you even realize that the pathology in the family courts is a delusional thought disorder, persecutory type (shared)? Or are you still continuing still to misdiagnose the pathology even now?

> **From the APA:** "Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way." (American Psychiatric Association, 2000)
>
> **From the APA:** "Usually the primary case in Shared Psychotic Disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person… Although most commonly seen in relationships of only two people, Shared Psychotic Disorder can occur in larger number of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs." (American Psychiatric Association, 2000)
>
> **From Walters & Friedlander:** "In some RRD families [resist-refuse dynamic], a parent's underlying encapsulated **delusion** about the other parent is at the root of the intractability (cf. Johnston & Campbell, 1988, p. 53ff; Childress, 2013). An encapsulated **delusion** is a fixed, circumscribed belief that persists over time and is not altered by evidence of the inaccuracy of the belief." (Walters & Friedlander, 2016, p. 426)
>
> **From Walters & Friedlander:** "When alienation is the predominant factor in the RRD [resist-refuse dynamic}, the theme of the favored parent's fixed **delusion** often is that the rejected parent is sexually, physically, and/or emotionally abusing the child. The child may come to share the parent's encapsulated **delusion** and to regard the beliefs as his/her own (cf. Childress, 2013)." (Walters & Friedlander, 2016, p. 426)
>
> Walters, M. G., & Friedlander, S. (2016). When a child rejects a parent: Working with the intractable resist/refuse dynamic. ***Family Court Review****, 54*(3), 424–445.

A clear professional statement from you that you understand that the pathology in the family courts is a shared (induced) persecutory delusion and false (factitious) attachment pathology created in the child for secondary gain to the narcissistic-borderline-dark personality parent would do much to reassure my professional concerns regarding your capability of applying the DSM-5 to a pathology (problem) you encounter. You're not trying to hide from the public that the pathology is a shared (induced) persecutory delusion, are you?

Is the pathology a shared persecutory delusion, Dr. Bernet? Is the pathology a false (factitious) attachment pathology imposed on the child for secondary gain to the pathological parent? If so, say so.

Will you apologize for the offensive statements you have made about PASG members on various internet sites?

Question 3: Will I apologize for making critical statements about you and other PASG member that you find displeasing?

Yes. I'm sorry for making statements about you or any other PASG member that you find distressing. If it will help end the child abuse in the family courts one day earlier, I will provide you with any apology you request for any statements I may have made that have been critical of you.

> **My Clarifying Question:** Does that include my current statements in this response to your questions in which I challenge your competence with the pathology, and in which I question whether you still continue to misdiagnose the pathology? Would you consider those to be "offensive statements" for which I must also apologize?

If so, I'm sorry for questioning your competence and your compliance with ethical standards of practice – Standards 2.01 Boundaries of Competence and 2.04 Bases for Scientific and Professional Judgments.

I am seeking membership to the PASG to request that the professional organization of the PASG begin active advocacy efforts to protect the children and parents in the family courts from child abuse and spousal abuse using the child as a weapon, pursuant to shared professional duty to protect obligations when the diagnoses of concern are V995.51 Child Psychological Abuse and V995.82 Spouse or Partner Abuse, Psychological.

In questioning (challenging) the professional competence of Dr. Lorandos, Ms. Gottlieb, and you, Dr. Bernet, I will also support my own competence in the required domains of delusional thought disorders, attachment pathology, child abuse, factitious disorders, and court-involved custody conflict. I note for your review and for the review of the PASG Board of Directors that I have demonstrated professional competence in multiple relevant domains of knowledge supported by my vita:[6]

> **Delusional Thought Disorders:** 12 years of annual training in the diagnostic assessment of delusional thought disorders at a UCLA-NIMH research project on schizophrenia (Nuechterlein), trained to r=.90 clinical and research reliability to the Co-Directors of the Diagnostic Unit at the UCLA/Brentwood VA – and co-authors of the *Brief Psychiatric Rating Scale* – Dr. Ventura and Dr. Lukoff.
>
> **Attachment Pathology:** I have Early Childhood Mental Health specialization – which is spot-on the attachment system and attachment pathology (a child rejecting a parent is an attachment pathology, a problem in the love-and-bonding system of

[6] Dr. Childress Domains of Specialized Expertise: https://drcachildress-consulting.com/wp-content/uploads/2023/01/domains-of-specialized-expertise-1-1-23-2.pdf

the brain). I know two additional early childhood diagnostic systems and two early childhood attachment treatments, and I'm certified in Infant Mental Health (spot-on attachment) from Fielding Graduate Institute.

Child Abuse: I served as the Clinical Director for a three-university assessment and treatment center for children ages zero-to-five in foster care. I am a trauma psychologist out of child abuse and foster care, that's why I am here in the family courts, this is my pathology, child abuse. You do understand what the pathology is, right?

Factitious Disorders: Factitious Disorder Imposed on Another (FDIA) is typically diagnosed by the pediatric psychologists at the local Children's Hospital. When the factitious pathology can't be diagnosed by community doctors, they refer up to higher levels of specialty practice until the pathology reaches the local Children's Hospital doctors. When the medical doctors at the Children's Hospital suspect FDIA, they ask the Psychology Department for a "psych consult" from the pediatric psychologist. That is the role I filled as a pediatric psychologist at two Children's Hospitals. I trained for three years at Children's Hospital of Los Angeles (CHLA), followed by a tenure on medical staff as a pediatric psychologist with Children's Hospital of Orange County (Choc). I am trained and experienced in the diagnosis of Factitious Disorder Imposed on Another.

Family Court Pathology: I have ten years of experience as a clinical psychologist in the family courts. I have explained the pathology that is in the family courts in detail (Childress, 2015; *Foundations*) across three levels of professional analysis – family systems – personality pathology – attachment. I am currently a testifying expert in the family courts, and I qualify to remain a testifying expert under Kayden's Law restrictions that will prevent by statute testimony from any expert without direct clinical experience with child abuse. I meet Kayden's Law requirements for direct clinical experience with child abuse (and spousal abuse). This summer I will also be presenting the *Contingent Visitation Schedule* (Childress, 2016) to the national convention of the *American Psychological Association* in Seattle.

Have you read the *Contingent Visitation Schedule*, Dr. Bernet? Do you understand the Strategic family systems principles on which it is based? I would offer for your consideration, Dr. Bernet, that if I have to educate you about any aspect of pathology, then you are not competent with the pathology by a demonstration of ignorance.

Google ignorance: lack of knowledge or information

Is that another rude statement for which you would like an apology, that I said you lacked professional knowledge because I must educate you about the pathology being a shared persecutory delusion and FDIA? Or do you know it's a shared delusion and FDIA and are just not saying so? Please clarify your diagnostic opinions at a professional level (DSM-5) for professional-level clarity.

I will copy the PASG Board of Directors, since they may have additional questions

for you to address.

I will await any additional questions from the Board of Directors of the PASG, and I ask that you relay to the Board of Directors the following proposal for resolution of any concerns they may have.

Resolution: Debate

Please pass along to the Board of Directors for the PASG my proposal for a resolution to any concerns – a formal online moderated professional Debate for any issue of professional concern.

I would propose to you, Dr. Bernet, that such a debate of Dr. Childress v Dr. Bernet on any topic – or a series of topics - would generate substantial worldwide attention and Internet views, bringing greater public interest and focus to the issues, educating the public and professionals, and offering solutions that will be to the substantial benefit of children and their parents in the family courts. Dr. Childress v Dr. Bernet on any issue you select would be an immense pubic interest generator. I'm in.

You pick the Topic. An online moderated 90-minute Debate on any topic you choose sponsored by the PASG: Dr. Childress v Dr. Bernet – pick a topic of your interest. Or if you'd like, I could suggest possible Debate topics for PASG sponsorship:

Topic 1: Is Parental Alienation a Real Pathology

Yes: Dr. Bernet

No: Dr. Childress

Topic 2: Is the Term Parental Alienation a Euphemism to Hide Child Abuse?

Yes: Dr. Childress

No; Dr. Bernet

Topic 3: Is Parental Alienation a Failed Diagnostic Model After 40 Years of No Change or Solution?

Yes: Dr. Childress

No: Dr. Bernet

Topic 4: Do We Need More Study or more Action to Solve the Pathology in the Family Courts?

More Study: Dr. Bernet

More Action: Dr. Childress

Topic 5: Is the Pathology in the Family Courts a Shared Persecutory Delusion?

Yes: Dr. Childress

No: Dr. Bernet??? Will you argue that the pathology is NOT a shared persecutory delusion or will you acknowledge that my diagnostic formulation is correct? I'm

not clear on your diagnostic position regarding the pathology. Do you agree that the pathology in the family courts is a shared (induced) persecutory delusion? Or do you disagree?

If you agree – say so clearly. If you disagree – let's formally and professionally Debate what we each think the pathology is.

Topic 6: Solutions for the Family Courts

Dr. Childress: Application of Established Knowledge

Dr. Bernet: Parental Alienation Syndrome

Or pick any topic. The Board of Directors for PASG can pick a topic. If you are not up for the challenge of defending your positions against professional challenge, then you and the Board of Directors for the PASG can select a champion to represent for you in a formal online moderated professional Debate if that's what you would like.

I understand if you decide that you are not personally up for the challenge of debating an issue and defending your positions. On your vita it says you graduated medical school in 1967. That's a long time ago. I was just entering high school when you were graduating medical school, so I estimate that you are about 15 years ahead of me (four for high school, four for college, and four for medical school) and I'll be 70 next year. We're old men now, Dr. Bernet. I grew up in the 1960s, you grew up in the 50s. We're not arriving, Dr. Bernet, we're leaving, and we should consider where we leave the field for the next generation of professionals.

Kayden's Law will effectively prohibit testimony about "parental alienation" – which of your self-proclaimed "experts" in "parental alienation" will meet the Kayden's Law criteria for expert testimony of direct clinical experience (not forensic experience) with child abuse and spousal abuse? There is no path to a solution using the construct of "parental alienation" proposed by a single psychiatrist in the 1980s and rejected by the *American Psychiatric Association* in 2013.

The application of established knowledge – attachment – complex trauma – personality disorders – the DSM-5 – provides a clear path forward into solutions and is required – mandatory – by Standard 2.04 of the APA ethics code.

We're old men, Dr. Bernet. You approaching 90, I understand if you no longer have the capacity to respond to a professional-level challenge to your ideas with formal Debate and discussion. Emeritus means retired, right Dr. Bernet? I'm not retired yet, Dr. Bernet. How long have you been retired from your professor position, ten years? I'm 69 and I am still active in the family courts. Are you still actively involved in assessments? Most recently I have been serving as a court-ordered second opinion on active assessments through telehealth. You've never done that have you Dr. Bernet?

If you are not up to defending your ideas from challenge, Dr. Bernet, then perhaps the PASG Board of Directors could select a PASG champion to replace you as your surrogate for a formal online moderated Debate on any topic the PASG selects – Dr. Childress v PASG representative – pick a topic.

Topic 7: Solutions for the Family Courts

Dr. Childress: The Return of Clinical Psychology to Court-Involved Practice

Dr. Bernet: ???

Bill

William Bernet, M.D.
Professor Emeritus, Vanderbilt University
Nashville, Tennessee, USA

Pick any topic you'd like. I await further questions from the PASG Board of Directors as desired. I look forward to working with the professional organization of the PASG toward our mutual goal of protecting children from child abuse in the family courts. That is your goal, right Dr. Bernet?

Craig Childress, Psy.D.
Clinical Psychologist, CA PSY 18857

Appendix 2: Competence Declaration of Dr. Childress

RESPONSE OF DR. CHILDRESS TO
DECLARATION OF DR. xyz

Dr. Xyz appears to be practicing beyond the boundaries of her competence when opining on court-involved child custody conflict.

1. **Competence:** Her professional background appears to be - vitae review - . She does not appear to have the necessary background by her education, training, or experience for court-involved child custody conflict.

2.01 Boundaries of Competence

> (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

a. Court-Involved Pathology:

The pathology of concern in the family courts is child abuse by one parent or the other, so competence in child abuse assessment and diagnosis is required.

- Either the targeted parent is abusing the child in some way, thereby accounting for the child's attachment pathology toward that parent,
- Or the allied parent is psychologically abusing the child by creating a shared (induced) persecutory delusion and false (factitious) attachment pathology in the child for secondary gain to the allied parent.

b. Persecutory Delusion:

Because the concern is a possible shared (induced) persecutory delusion with the parent as the primary case, competence in the assessment and diagnosis of delusional thought disorders is required.

Walters & Friedlander (2016)

c. Attachment Pathology:

The pathology in the family courts is an attachment pathology, a problem in the love-and-bonding system of the brain, so competence in the diagnostic assessment of attachment pathology is required.

d. Family Systems:

The pathology in the family courts is a severe family conflict, so competence in the assessment and diagnosis of family systems pathology is required. Dr. Xyz's vitae evidences none of those required domains of professional competence based on her education, training, and professional experience. She's worked in - vitae review -

not in the family courts. For her to be intruding herself into a court-involved custody conflict as an ally to the parent-client is inappropriate. - case specific & dependent -

2. **Personality Pathology:** [redacted] case specific argument [redacted]:

From Dr. Other Name: "[redacted] case specific argument [redacted]," [redacted] case specific argument [redacted].

Note: If Dr. Xyz believes a shared delusion, then Dr. Xyz becomes part of the shared delusion, she becomes part of the pathology. Did Dr. Xyz conduct a proper assessment to support her diagnosis of PTSD secondary to spousal abuse by the father? Did Dr. Xyz interview the father to hear his side of the spousal conflict? - case specific & dependent -

3. **"Negligence"** (per Google): Failure to take proper care in doing something

4. **Interviewing Both Parties**

If Dr. Xyz did not interview all the parties to the matter, then she only has biased information acquired from one source, her client. Based on this limited source of information, her opinions as expressed in her declaration to the court do not appear to be based on information and techniques sufficient to substantiate her findings that the father engaged in spousal abuse of the mother. - case specific & dependent -

9.01 Bases for Assessments

> (a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

Dr. Xyz never interviewed the father. The concern from the father's position is that the mother has a persecutory delusion. Is Dr. Xyz competent in the diagnosis of persecutory thought disorders? Where and how did she acquire this competence? Does Dr. Xyz know how to conduct a Mental Status Exam of thought and perception? Where and how did she acquire this competence?

5. **Mental Status Exam**

> **From Martin:** "The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these concerns elevated to the level of irrational

fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?"

From Martin: "Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary-care physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders."

Did Dr. Xyz conduct a proper assessment of the potential pathology in the family sufficient to support her diagnosis, or did she misdiagnose a persecutory thought disorder in her patient?

6. Ethical Concerns

Based on the information provided in the declaration of Dr. Xyz, multiple professional concerns emerge, with two possible ethical violations to Standard 2.01 Boundaries of Competence and 9.01 Bases for Assessment that potentially result in the libelous slander of father's reputation by publicly designating him as a confirmed spousal abuser when that is not supported by her assessment. - case specific & dependent -

Whether the declaration of Dr. Xyz represents defamation of the father's reputation, harming him within the community, based on an inadequate assessment conducted by Dr. Xyz is a legal issue, and I'm a clinical psychologist. The public reports of doctors need to be accurate and contained to the information, and a proper assessment is needed to support public allegations of child abuse or spousal abuse.

Craig Childress, Psy.D, May 3, 2024

Craig Childress, Psy.D, (May 3, 2024 06:55 PDT)

Craig Childress, Psy.D.

Clinical Psychologist, CA PSY 18857